Administrative Simplification and Standardization of Medical Claim Forms

ISSUE

Can we save billions of dollars in our healthcare delivery system through administrative simplification and standardization?

BACKGROUND

There are more than 1300 insurance companies operating throughout the United States. Many companies offer dozens of different types of health insurance. Insurance products vary from state-to-state, insurer-to-insurer and patient-to-patient.

According to the American Medical Association, as much as 14 percent of a physician’s total time and resources are dedicated to claims collections. Even when physicians submit correctly coded health care claims, health insurers and other third-party payers still inappropriately delay, deny or significantly reduce payments.

From pre-paid healthcare to high-deductible HSAs, providers are confronted with a myriad of health plans, insurance policies and filing requirements. The process of generating a medical claim for a service and getting paid the appropriate amount from an insurance company can be time-consuming, costly and can create unnecessary overhead.

Examples of administrative overhead that can be addressed through effective administrative simplification include:

* Health plan enrollment
* Paying health insurance premiums
* Checking insurance eligibility for a particular service
* Getting an authorization to refer a patient to a specialist
* Filing a claim for payment for health care that has been delivered
* Requesting or responding to additional information in support of a claim
* Coordinating the payment of a claim involving two or more insurance companies
* Notifying the provider about the payment of a claim

In 1996, Congress passed and President Clinton signed into law the Health Insurance Portability and Accountability Act or HIPAA. HIPAA was intended to address all of the issues mentioned above. According to the Department of Health and Human Services, the agency charged with implementing and enforcing HIPAA, full implementation of HIPAA could save billions of dollars per year from reduced overhead, without reducing the quality of health care.

To make these administrative savings a reality, the 1996 law required the Secretary of HHS to adopt uniform national standards for the electronic processing of insurance claims and related transactions within 18 months of the law’s enactment. Health plans, providers, and insurers would then have 24 months to implement the standards. These transaction code set standards went into effect in 2001 but have only been partially implemented by payers and the savings promised by HIPAA have never been fully realized by the provider community.
**DISCUSSION**

Providers deserve to be paid promptly and efficiently for the services they render. Despite the enactment of HIPAA and the publication of the electronic claims transaction standards, the current system still leads to inappropriate payments, long delays in receiving payment and an inefficient payment system.

When HHS set the uniform electronic transaction standards in 2001, it permitted insurance companies (and state Medicaid agencies) to issue what are referred to as “companion guides”. These are health plan specific manuals that accompany the “electronic claims transaction standards” that spell out the plan specific claims submission criteria. In other words, even though there is single set of transaction standards, each health plan can issue plan specific criteria that render the uniform standards meaningless.

In addition, despite the issuance of uniform electronic transaction standards, CMS (the agency within HHS charged with developing and overseeing these standards) has never issued instructions on electronic claims attachments. For example, it is often necessary to send an X-ray to an insurance company in order to justify a particular level of payment. Because there are no electronic standards for attachments, X-rays must be sent “hard copy” and then manually attached to the electronic claim once the attachment has been received in the mail by the insurer. This adds significant time and cost to the claims transaction and needlessly delays either treatment or payment.

Recently, representatives of the health insurance industry announced that more than $750 Billion in unnecessary health care costs could be saved through administrative simplification and standardization. As medical billing and practice management experts, we have no doubt that billions could and must be saved through administrative simplification. However, we do not need HIPAA II, we simply need to have the complete HIPAA Administrative Simplification process finalized and enforced.

**RECOMMENDATIONS:**

1. Outlaw Companion Guides and require Health Plans (including all state government plans) to adhere to the Uniform Transaction Code Set Standards as promulgated.
2. Give CMS/HHS true enforcement authority, including the levying of fines on health plans that fail to adhere to the Uniform Transaction Code Set Standards.
3. Direct CMS to issue final standards for electronic claims attachments and allow providers to submit claims attachments with the original electronic claim.
4. Mandate use of the key fields included in the electronic remittance advice (ERA) necessary for physicians to efficiently reconcile claims; provide expanded electronic patient eligibility responses, and use consistent, accurate, specific reason and remark codes so that the physician can easily confirm whether an adjustment on a claim was indeed accurate.

The significant savings that could be realized by more efficient claims processing could be better spent increasing the quality of patient care and reducing the burden of high premium costs to patients and their employers.